



**Pioneer Counseling Center**  
**Authorization to Release Information**

Client Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Soc. Sec #: \_\_\_\_\_

I hereby freely and voluntarily authorize: **Pioneer Counseling Center**

to release the information specific below to: **MINUTE MAN SERVICES INC.**

Address: **3318 N. MAIN**

City, State, Zip **ROYAL OAK, MI 48073**

I am aware of the specific type of information being disclosed and understand the benefits and/or disadvantages of disclosing the information. Pioneer Counseling Center and its affiliates, representatives and assigns are hereby released from all legal liabilities that may result from the release of their information specific below.

I have previously consented to the use and disclosure of my individually identifiable health information for treatment, payment and health care providers.

Disclosure shall be limited to the following specific information contained in my records and/ or obtained during the course of my diagnosis and treatment; The information that I authorize to be released is limited to:

**Please check off YES or NO for each item)**

- |  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| • Assessment and Diagnostic Summaries  | <input type="checkbox"/> | <input type="checkbox"/> |
| • Psychiatric Evaluation               | <input type="checkbox"/> | <input type="checkbox"/> |
| • Laboratory Information               | <input type="checkbox"/> | <input type="checkbox"/> |
| • Medication Regime                    | <input type="checkbox"/> | <input type="checkbox"/> |
| • Progress Notes (Specify Dates) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| • Record of Attendance                 | <input type="checkbox"/> | <input type="checkbox"/> |
| • Discharge Summary                    | <input type="checkbox"/> | <input type="checkbox"/> |
| • Other: Specify _____                 | <input type="checkbox"/> | <input type="checkbox"/> |

The purpose and need for such disclosure: \_\_\_\_\_

The client may revoke this authorization at any time, except to the extent that the action has been taken in reliance of this consent prior to revocation. If not previously revoked, this consent will expire on:

\_\_\_\_\_ Date of expiration

**This consent provides for a release of information concerning an individual whose confidentiality is protected by Title 42 of the Code of Federal Regulations, Part II and CFR Part 160 – 165, in accordance with the authority specified in Public Act 56 of 1973 and in compliance with Section 748, Act 258, "Michigan Mental Health Code".**

**ANY FURTHER DISCLOSURE OF THIS INFORMATION IS NOT PERMITTED WITHOUT THE SPECIFIC AUTHORIZATION TO DO SO.**

\_\_\_\_\_  
Client's Signature (or Guardian)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature  
Revised 10/99,4/11/2003

\_\_\_\_\_  
Date